pennsylvania
DEPARTMENT OF HUMAN SERVICES
OFFICE OF LONG TERM LIVING

Vendor Payment Request Form

Participant Name:	Participant ID:	Date:

Payment Instructions			
Make Check Payable to:		FEIN or SSN of Payee:	
Mailing Address:	City:	State:	Zip Code:
Name of Individual Providing the Service (if different than above):			
Address:	City:	State:	Zip Code:

Please attach a copy of the purchase order, invoice, vendor quote, or transportation log.

Date	Service Procedure Code	Description	Total Amount
		Total Check Amount	

By signing this form, I attest that the vendor is qualified to render this service. I also attest that services were delivered and received consistent with the Individual Support Plan. I understand that Medicaid is the payer of last resort. I have confirmed that the vendor/small unlicensed provider/independent contractor have met the wavier qualification criteria that is outlined in the current approved waiver.

Common Law Employer's Signature: Date:

Please verify the following qualifications for the person or entity that provides the participant-directed services. Office of Long Term Living (OLTL) Vendor services are: Participant-Directed Goods and Services.

Qualification Validated	Qualification Requirement	Provider Type
	At least 18 years of age	Individual
	Have the required skills to perform Participant-Directed Goods and Services as specified in the consumer's service plan	Individual
	Possess a valid Social Security number	Individual
	Meets applicable state and local regulations and/or Medicaid provider qualifications for the type of service the provider/supplier is providing as written in the participant's Spending Plan.	Individual or Agency
	Meets the acceptable industry standards for the goods or services they provide	Individual or Agency
	Has entered into a Medicaid provider agreement with each	Agency